TO THE EDITOR, *Genitourinary Medicine*

Treatment of herpes genitalis with new topical agent, Allay gel

Sir,

Two studies reported treating herpes genitalis with antiviral agents topically and systemically.[1,2] In those studies the topical treatment was an adjunct to systemic treatment, and we report the use of a wide range antimicrobial agent, Allay, as the sole treatment of initial episodes of herpes genitalis.

Allay gel is a preparation that has as its active ingredient a buffered mixture of chlorous acid and chlorine dioxide. It is a wide range antimicrobial agent, which also has antifungal and antiviral activities.[3,4] The preparation is presented as a pair of unit dose sachets, the contents of which are mixed immediately before use. The patients were provided with an illustrated instruction sheet to facilitate compliance. A 2 g quantity of gel containing 0·16% of active ingredient expressed as chlorite was prepared by mixing the contents of the sachets, and was applied by each patient twice a day for seven days.

We enrolled 35 patients (30 men, five women) in a pilot investigation; 34 were confirmed by standard tissue culture technique as having herpes genitalis. Three received Allay three times a day. One patient defaulted before treatment was assessed. All patients were examined on day one and every alternate day until healing had occurred (which was defined as re-epithelialisation of the original lesion). Seven days after healing, a microbiological sweep was made over the affected area to confirm the absence of herpes simplex virus.

The table shows the results in 31 patients evaluated for efficacy and comparative data from a published study by Fiddian *et al* comparing topical acyclovir with placebo.[1] Data on recurrences were not easy to obtain, but three months later recurrences had been noted in 13 patients, no recurrences in five, and 13 had not yet returned to the clinic.

Side effects noted were stinging on application in one patient and a possible allergic reaction in the first two of the 31 patients, which may have been caused by a wetting agent that has subsequently been removed from the preparation. Patient compliance was good. Of particular interest was the rapid reduction in pain and discomfort and the very clean appearance of the lesions and surrounding skin at day three, which possibly reflected Allay's range of activity. Positive factors mentioned by patients were the twice a day dosage (compared with acyclovir five times a day) and the formation of a dry protective film over the lesions, which reduced odour and provided a sanitising effect.

From this pilot study we conclude that topical treatment with Allay gel shows sufficient promise to justify its further investigation in a controlled evaluation compared with other topical treatments against primary and recurrent herpes genitalis.

The agent was kindly supplied by Alcide Corporation, Norwalk, Connecticut, USA, and the distributors were Macarthy Medical, Romford.

Table *Results of treatment with Allay compared with acyclovir and placebo*

Treatment	n	Median duration (in days) of: Symptoms	Viral shedding	Healing
Allay	31	3	1	8
Acyclovir	54	5	3	7–8
Placebo	47	8	6–9	10–13

Yours faithfully,
A G Lawrence

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TO THE EDITOR, *Genitourinary Medicine*

Role of sexually transmissible pathogens in transmitting HIV I

Sir,

Sexually transmitted diseases (STD) constitute a major health problem in most developing countries,[1] and this was accentuated recently by the advent and spread of sexually transmitted retroviral infections that cause the lethal acquired immune deficiency syndrome (AIDS). STD, particularly those that cause genital ulcerations, could be important in enhancing the transmission of human immunodeficiency virus (HIV).[2] To evaluate this hypothesis, the analysis of the seroprevalence of antibodies to a number of STD could be useful and a study was done on the sera of women (15–54 years old) living in south eastern Gabon.

Sera from 734 women were screened for treponemal infection by the semiquantitative Venereal Disease Research Laboratory (VDRL) test (Diagnostics Pasteur), and positive results were confirmed by the quantitative *Treponema pallidum* haemagglutination assay (TPHA) (Berhing Diagnostic). A positive TPHA result at a titre of 1/80 or more was considered as diagnostic. The sera were screened for antibodies to *Neisseria gonorrhoeae* by a Go-pili enzyme linked immunosorbent assay (ELISA) and to *Chlamydia trachomatis* by a microimmunofluorescence technique (cut off titre 1/64). Antibodies to HIV I were detected by ELISA (Elavia; Diagnostics Pasteur) and positive results were confirmed twice by western blot (LAV Blot1; Diagnostics Pasteur).

The table shows the result of western blot tests in relation to results of serological tests for other STD. Significantly more women with treponemal infection had antibodies to core proteins only ($p < 0·001$) than were found in those without syphilis. No differences were seen in the incidence of HIV I (antibodies to core and envelope proteins) between women with and without antibodies to *T pallidum*. No differences in the incidence of retroviral infection were seen between sera positive for *N gonorrhoeae* and *C trachomatis*.

Antibodies to core proteins only may indicate a recent infection, infection by an atypical retrovirus, or a false positive reaction. An atypical HIV I strain was recently isolated in women presenting antibodies to core proteins, the presence of which were the only indication of retroviral infection.[3] Only women with a treponemal infection had an appreciably greater incidence of retroviral infection, which could indicate that *T pallidum* facilitates the transmission of retroviruses, possibly by causing genital ulceration.

Yours faithfully,
*D Schrijvers**†
*E Delaporte**
*M Peeters**
A Meheus†

Table *Incidence of HIV I infection in 734 women by western blot in relation to incidence of Treponema pallidum, Chlamydia trachomatis, and Neisseria gonorrhoeae (figures numbers (and percentages))*

Results on western blot	T pallidum		C trachomatis*		N gonorrhoeae†	
	Negative (n = 661)	Positive (n = 72)	Negative (n = 310)	Positive (n = 415)	Negative (n = 506)	Positive (n = 223)
Antibodies to:						
Core proteins	18 (2·7)	8 (11·1)	11 (3·5)	15 (3·6)	16 (3·2)	10 (4·5)
Core and envelope proteins	8 (1·2)	1 (1·4)	6 (1·9)	3 (0·7)	7 (1·4)	2 (0·8)

*Results not available for nine women.
†Results not available for five women.

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TO THE EDITOR, *Genitourinary Medicine*

Persistence of high risk activity in homosexual men

Sir,

Reports from the United States of America indicate that nearly half the homosexual men living in areas of low prevalence for human immunodeficiency virus (HIV) infection persistently engaged in high risk activity.[1,2]

During January 1985 to July 1987 196 homosexual men (excluding bisexual men) presented to the department of genitourinary medicine in Sheffield and were counselled before being screened for antibody to HIV. Of those presenting, 19 (10%) were found to be HIV seropositive, 22 (11%) had gonorrhoea, and three (2%) had infectious syphilis.

Of the 177 men who were initially HIV antibody negative, 84 (mean (SD) age 26 (7) years) subsequently reattended (32 at 6–12 months, 29 at 13–18 months, 10 at 19–24 months, and 13 after more than 25 months; mean time from initial testing to reattendance was 12 months). The table shows that no significant difference in the incidence of gonorrhoea was seen at their second visits. Only one man who had presented initially with gonorrhoea subsequently attended with the same condition. Of the 84 men, 79 (94%) were tested again for antibody to HIV, and three of them were found to be HIV seropositive. The numbers with a regular sexual partner, casual partners, or both regular and casual partners had not changed appreciably since their initial attendance. At reattendance significantly more homosexual men were engaged in safe sex practices with casual partners ($\chi^2 = 12{\cdot}8$, $p < 0{\cdot}01$), although there was no significant difference in sexual practices with regular partners.

Table *Results of tests for 84 homosexual men at initial and subsequent attendances and types of sexual partners and safe sex practices undertaken during three months before each visit (figures are numbers (percentages of those in category) of men)*

	Initial attendance (n = 84)	Re-attendance (n = 84)
With gonorrhoea	5 (6·0)	6 (7)
Tested for HIV antibody	84 (100)	79 (94)
Seropositive for HIV	0	3 (4)
Types of sexual partners:		
Regular only	27 (32)	30 (36)
Regular and casual	15 (18)	17 (20)
Casual only	42 (50)	31 (37)
None	0	6 (7)
Activities with regular partners:	(n = 42)	(n = 47)
No penetrative sex	6 (14)	9 (19)
Condoms used	1 (2)	7 (15)
No safe sex practised	35 (83)	31 (66)
Activities with casual partners:	(n = 57)	(n = 48)
No penetrative sex	8 (14)	10 (21)
Condoms used	0	13 (27)
No safe sex practised	49 (86)*	25 (52)*

HIV = human immunodeficiency virus.
*$p < 0{\cdot}01$.

In this group of men there was a change towards fewer casual partners and safer sexual practices, which reflects the effect of counselling in the clinic. We also confirm results from the United States regarding the persistence of high risk sexual activity in homosexual men, which implies the need to reinforce health education in this group of men.

Yours faithfully,

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TO THE EDITOR, *Genitourinary Medicine*

Markers of sexually transmitted diseases in prostitutes in central Tunisia

Sir,

Lack of accurate data on sexually transmitted diseases (STD) in the general population or in high risk groups is a major problem, and the spread of STD in north Africa is inevitable with the development of tourism.

Prostitutes are important in the spread of STD. As more attention is again being directed towards this group because of the advent and spread of human immunodeficiency virus (HIV) infection, we undertook a study on markers of STD (including HIV) in 42 female prostitutes. For comparison, a group of 342 male and female university students were used. The study period was the first trimester of 1987. Serological tests performed included: two enzyme linked immunosorbent assays (ELISAs) (Elavia 1 and Wellcome) for HIV; the microimmunofluorescence (MIF) test (Biosys) at a titre of more than 1/16 for *Chlamydia trachomatis*; enzyme immunoassays (EIAs) (Abbott) for hepatitis B surface antigen (HBsAg)g; and antibodies to HBsAg and hepatitis core antigen (HBcAg); and the Venereal Disease Research Laboratory (VDRL) test and the *Treponema*